DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155484	B. WING			R 12/21/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	CTION SHOULD BE COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000			
	Paper compliance to and state licensure s November 16, 2012.						
	Review Date: December 21, 2012						
	Facility Number: 000 Provider Number: 15 AIM Number: 10028	55484					
	Surveyor: Deborah M. Beers, R.N.						
	42 CFR Part 483, Su	d to be in compliance with bpart B and 410 IAC 16.2, in ompliance review to the					
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> E		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.